
Personal Health and Medical Record

Camper/Staff Member Name

Date of Birth

Home Address

Home Phone

City, State, Zip

Social Security Number

In Case of Emergency, Notify:

Mother/Guardian Name

Home Phone

Work Phone

Cell Phone

Father/Guardian Name

Home Phone

Work Phone

Cell Phone

Emergency contact

Relationship

Home Phone

Cell Phone/Other Phone

Emergency Medical Information

Has or is Subject to:

___ Asthma

___ Convulsions

___ Contact Lenses

___ High Blood Pressure

___ Diabetes

___ Fainting Spells

___ Eating Disorder

___ Heart Trouble

___ Allergy/reaction to any medicine,
food, plant, or insect toxin

___ Any condition that may require emergency
care, medication, or knowledge

Brief Explanation _____

Activity Restrictions: _____

Dietary Restrictions : _____

Immunizations

Vaccines:

Date Series Completed

Date of Booster

___ Tetanus

___ Diphtheria

___ Polio

___ Heb B

___ Chicken Pox

Medical History

Most recent Medical Examination (Date) _____ Current Health Problems: _____ Yes _____ No

Now under Medical Care _____ Yes _____ No
 (Explain below) Any surgery, illness, allergy, or change in health status
 Since last medical exam? _____ Yes _____ No
 (Explain below)

List medications taken on a regular basis in the past year.

List below any medication to be administered while at camp, prescription or discretionary.

Past/Present Medical History

Check "Yes" and give the year for any past or current health problems. Explain all topics checked below.

<u>Yes</u>	<u>Problem</u>	<u>Year</u>	<u>Yes</u>	<u>Problem</u>	<u>Year</u>
_____	Serious Illness	_____	_____	Heart Murmur	_____
_____	Serious Injury	_____	_____	Rheumatic Fever	_____
_____	Deformity	_____	_____	Stomach/Bowels	_____
_____	Surgery	_____	_____	Appendicitis	_____
_____	Skin/Glands	_____	_____	Menstrual Problems	_____
_____	Ears	_____	_____	Hernia	_____
_____	Eyes	_____	_____	Back	_____
_____	Nose/Sinus	_____	_____	Joints	_____
_____	Teeth	_____	_____	Sleepwalking	_____
_____	Braces	_____	_____	Behavioral Condition	_____
_____	Dentures	_____	_____	Kidney/Bladder	_____
_____	Bridge	_____	_____	Infection	_____
_____	Throat/Tonsils	_____	_____	Bedwetting	_____
_____	Chest/Lungs	_____	_____	Other (Below)	_____

Explanation of all checked topics: _____

Name of Physician _____ Phone Number _____
 Name of Insurance Company _____ Phone Number _____ Policy Number _____
 Name of Insured _____ Member Number _____

Enclose on a separate paper a copy of the front and back of your Insurance Card.

Authorization

To the best of my knowledge, this history is correct and complete. I know of no reason to restrict this individual's activity and give my permission for participation in all activities except as specifically noted herein. In the event that I cannot be reached in an **emergency**, I hereby give permission to the physician selected by the camp director or her designee to hospitalize, secure proper treatment for and to order injection, anesthesia, or surgery for my child as named above.

Date _____ Signature of Parent/Guardian _____ Signature of individual (if over 18) _____